INFORMATION FOR FOSTER PARENTS
PART A

Dear Foster Parent:

The attached forms and information are provided to you according to s. 895.485(4)(a), Wis. Stats., and ch. HFS 37, Adm. Code. We have tried to give you all of the information indicated on the forms, but we often do not have complete information at the time of placement.

Together we are partners in the provision of services for this child. Therefore, we must both try to gather and share information on this child. Add information to this form whenever you gather it; e.g., from the child or his / her family or from a physician. We shall also continue to provide you with information.

During our later visits, we will share with each other any new information that becomes available.

All of the information regarding this foster child provided to you on these forms and in any other manner, is done so with the expectation that you will maintain the information in confidence. State and federal statutes require that this information be kept confidential. If you have any questions regarding what information you may share with any party (e.g., health care providers, schools), please contact the child's social worker.

This first section, Part A, Face Sheet, contains information that is critical for foster parents to know as soon as the child first enters placement. Some of the material is repeated elsewhere in the form.

Note: If the space provided on the form is not adequate, make a note that information is continued on the back or a separate sheet of paper. Clearly indicate which section or item number any supplemental information pertains to.

INFORMATION FOR FOSTER PARENTS - PART A
FACE SHEET

Use of form: The information contained in this form must be provided to the foster parent at the time of placement unless there is no way to gather the information prior to the child's placement. Information not provided at the time of placement must be provided within 48 hours. If additional space is needed when completing this form, attach separate sheet(s).

I. GENERAL INFORMATION (Critical Facts to Know)

Date Form Filled Out (mm/dd/yyyy)	Date Child Placed in Foster Care (mm/dd/yyyy)

A. Child Information

Name - (Full Legal)			Nicknames(s)
Birthdate (mm/dd/yyyy)		Gender ☐ Female ☐ Male	Social Security Number
Height	Weight	Religious Belief or Affiliation - Child or Family	

B. Parent Information

Name - Mother	Mother is Child's ☐ Birth mother ☐ Stepmother ☐ Adoptive mother
Address (Street, City, State, Zip Code)	
Telephone Number - Home	Telephone Number - Work
Name - Father	Father is Child's ☐ Birth father ☐ Stepfather ☐ Adoptive father
Address (Street, City, State, Zip Code)	
Telephone Number - Home	Telephone Number - Work

C. Placement Reason (Allegation)

☐ Yes ☐ No The child was previously in the child welfare system.
☐ Yes ☐ No The child was removed from his or her own home.
☐ Yes ☐ No The child was removed from another foster home.

D. Emergency Contact Person

Name	Telephone Number

E. Social Worker / Agency / Agency Secondary Contact

Name - Child's Social Worker With Whom Foster Parent Will Have Contact	Telephone Number - Social Worker
Name - Social Worker's Agency	Telephone Number - Agency
Name - Agency's Secondary Contact (e.g. supervisor)	Telephone Number - Secondary Contact Regular Hours / After Hours

F. MA Card

☐ Yes ☐ No Has the out-of-home care provider been given the child's MA card (regular or temporary)?
If "No", describe how and when it will be provided.

G. Prohibited Contacts and Visitors

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

H. a. Physician - Child's

Name	Telephone Number

b. Mental Health Provider

Name	Telephone Number

I. School Currently Attending or Most Recently Attended

Name

Address (Street, City, State, Zip Code)

J. Physical Characteristics - Child

Describe; e.g., scars, tattoos, birthmarks, discolorations, etc.

K. Behavioral Issues - Child

Describe; e.g., fire setting, physically abusive, sexually abusive, etc.

L. a. Medical or Mental Health Diagnoses

☐ Yes ☐ No Child has been diagnosed with a medical / developmental or mental health problem.
If "Yes", specify.

L. b. Non-Medical or Mental Health Diagnoses

☐ Yes ☐ No Child is believed to have a medical / developmental or mental health problem. If "Yes", specify.

M. Medications

☐ Yes ☐ No Child is currently taking medication(s). If "Yes", specify.

1.	Name of Medication	Dosage / Frequency
	Reason for Medication	Prescribing Physician

☐ Yes ☐ No Have you provided this medication to the care provider? If "No", explain.

2.	Name of Medication	Dosage / Frequency
	Reason for Medication	Prescribing Physician

☐ Yes ☐ No Have you provided this medication to the care provider? If "No", explain.

3.	Name of Medication	Dosage / Frequency
	Reason for Medication	Prescribing Physician

☐ Yes ☐ No Have you provided this medication to the care provider? If "No", explain.

4.	Name of Medication	Dosage / Frequency
	Reason for Medication	Prescribing Physician

☐ Yes ☐ No Have you provided this medication to the care provider? If "No", explain.

N. Special Medical Equipment Needs - Child

☐ Yes ☐ No Child has special medical equipment needs; e.g., feeding tubes, respirator, wheelchair, prosthetics. If "Yes", specify.

O. Allergy(s) - Child

☐ Yes ☐ No Child has allergies. If "Yes", check all applicable allergies.

☐ Animals ☐ Insect bites ☐ Stings ☐ Soap
☐ Food ☐ Drugs ☐ Dairy products ☐ Wool
☐ Other - Specify:

Allergy(s) Details; e.g., if you checked "Animals", is the allergy to all animals, or a specific type? Specify type.

Noticeable Allergy Reactions - Describe.

P. Formula and Feeding Restrictions

☐ Yes ☐ No Child is currently fed with formula. If "Yes", specify brand and type.

☐ Yes ☐ No The child has feeding restrictions; e.g., solids, cups or bottles, swallowing problems. If "Yes", specify.

Q. Therapeutic Exercises / Activity Restrictions

☐ Yes ☐ No Child is required to participate in any therapeutic exercises. If "Yes", specify nature of those exercises.

☐ Yes ☐ No Child is restricted from certain activities; e.g., strenuous exercise, climbing stairs, etc. If "Yes", specify activity(s).

R. Medical or Mental Health Appointments

☐ Yes ☐ No Does the child have any currently scheduled medical or mental health appointments? If "Yes", specify.

Date (mm/dd/yyyy)	Time	Name - Provider

II. SIGNATURES

SIGNATURE - Placing Social Worker _____ Date Signed _____

SIGNATURE - Foster Parent _____ Date Signed _____

SIGNATURE - Foster Parent _____ Date Signed _____